		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040931

Facility Name: COUNTRYSIDE CARE CENTRE

Address: 2330 W. GALENA (Number) AURORA (City) 60506 (Zip Code)

County: KANE

Telephone Number: (630) 896-4686 **Fax #** (630) 896-7868

IDPA ID Number: 36-3961908

Date of Initial License for Current Owners: 07/01/94

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHAEL BELLOWS
(Title) MANAGEMENT CONSULTANT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 03/19/02

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	131	Skilled (SNF)	131	47,815	1
2		Skilled Pediatric (SNF/PED)			2
3	78	Intermediate (ICF)	76	27,894	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	209	TOTALS	207	75,709	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,511	1,454	7,924	13,889	8
9	SNF/PED					9
10	ICF	42,073	13,327	3,773	59,173	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	46,584	14,781	11,697	73,062	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.50%

D. How many bed-hold days during this year were paid by Public Aid?
338 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 07/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/01/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 19 and days of care provided 3,490

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	294,585	27,945	12,887	335,417		335,417	(8,287)	327,130			1
2	Food Purchase		252,163		252,163		252,163	(1,881)	250,282			2
3	Housekeeping	216,346	36,151		252,497		252,497	(2,469)	250,028			3
4	Laundry	67,315	25,969	8,995	102,279		102,279	1,501	103,780			4
5	Heat and Other Utilities			190,006	190,006		190,006		190,006			5
6	Maintenance	45,110	36,663	57,425	139,198		139,198	13	139,211			6
7	Other (specify):*			33,783	33,783		33,783		33,783			7
8	TOTAL General Services	623,356	378,891	303,096	1,305,343		1,305,343	(11,123)	1,294,220			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	3,524,015	134,832	182,841	3,841,688		3,841,688	(4,301)	3,837,387			10
10a	Therapy	89,444		14,933	104,377		104,377		104,377			10a
11	Activities	138,009	8,362	12,844	159,215		159,215	92	159,307			11
12	Social Services	54,451		3,535	57,986		57,986		57,986			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,805,919	143,194	226,153	4,175,266		4,175,266	(4,209)	4,171,057			16
	C. General Administration											
17	Administrative	206,817		806,893	1,013,710		1,013,710	(792,815)	220,895			17
18	Directors Fees											18
19	Professional Services			214,274	214,274		214,274	16,247	230,521			19
20	Dues, Fees, Subscriptions & Promotions			90,625	90,625		90,625	(60,215)	30,410			20
21	Clerical & General Office Expenses	159,108	43,316	56,931	259,355		259,355	150,855	410,210			21
22	Employee Benefits & Payroll Taxes			785,871	785,871		785,871		785,871			22
23	Inservice Training & Education			31,365	31,365		31,365		31,365			23
24	Travel and Seminar			1,591	1,591		1,591	11,204	12,795			24
25	Other Admin. Staff Transportation			6,206	6,206		6,206		6,206			25
26	Insurance-Prop.Liab.Malpractice			190,611	190,611		190,611	205,389	396,000			26
27	Other (specify):*			416,916	416,916		416,916	(416,916)				27
28	TOTAL General Administration	365,925	43,316	2,601,283	3,010,524		3,010,524	(886,251)	2,124,273			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,795,200	565,401	3,130,532	8,491,133		8,491,133	(901,583)	7,589,550			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE #0040931 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			102,172	102,172		102,172	167,836	270,008			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			179,702	179,702		179,702	339,286	518,988			32
33	Real Estate Taxes			100,485	100,485		100,485		100,485			33
34	Rent-Facility & Grounds			762,850	762,850		762,850	(741,939)	20,911			34
35	Rent-Equipment & Vehicles			21,283	21,283		21,283	9,645	30,928			35
36	Other (specify):*											36
37	TOTAL Ownership			1,166,492	1,166,492		1,166,492	(225,172)	941,320			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		216,153	356,084	572,237		572,237		572,237			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			113,564	113,564		113,564		113,564			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		216,153	469,648	685,801		685,801		685,801			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,795,200	781,554	4,766,672	10,343,426		10,343,426	(1,126,755)	9,216,671			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(38,549)	30		9
10	Interest and Other Investment Income	(26,417)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,881)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(211)	21		18
19	Entertainment		20		19
20	Contributions	(5,720)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(1,808)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(416,916)	27		24
25	Fund Raising, Advertising and Promotional	(42,206)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(14,307)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(42,258)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (590,273)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(536,482)	PG. 6&6A	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (536,482)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,126,755)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

COUNTRYSIDE CARE CENTRE

ID# 0040931

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ (1,037)	6	1
2	VACATION ACCRUAL	(8,287)	1	2
3	VACATION ACCRUAL	(2,469)	3	3
4	VACATION ACCRUAL	1,501	4	4
5	VACATION ACCRUAL	1,050	6	5
6	VACATION ACCRUAL	(18,352)	10	6
7	VACATION ACCRUAL	92	11	7
8	VACATION ACCRUAL	(7,389)	17	8
9	VACATION ACCRUAL	(7,367)	21	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(42,258)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(8,287)	0	0	0	0	0	0	0	0	0	0	(8,287)	1
2	Food Purchase	(1,881)	0	0	0	0	0	0	0	0	0	0	(1,881)	2
3	Housekeeping	(2,469)	0	0	0	0	0	0	0	0	0	0	(2,469)	3
4	Laundry	1,501	0	0	0	0	0	0	0	0	0	0	1,501	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	13	0	0	0	0	0	0	0	0	0	0	13	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(11,123)	0	0	0	0	0	0	0	0	0	0	(11,123)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(18,352)	14,051	0	0	0	0	0	0	0	0	0	(4,301)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	92	0	0	0	0	0	0	0	0	0	0	92	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(18,260)	14,051	0	0	0	0	0	0	0	0	0	(4,209)	16
	C. General Administration													
17	Administrative	(7,389)	(785,426)	0	0	0	0	0	0	0	0	0	(792,815)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,808)	6,980	11,075	0	0	0	0	0	0	0	0	16,247	19
20	Fees, Subscriptions & Promotions	(62,233)	2,018	0	0	0	0	0	0	0	0	0	(60,215)	20
21	Clerical & General Office Expenses	(7,578)	157,840	593	0	0	0	0	0	0	0	0	150,855	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	11,204	0	0	0	0	0	0	0	0	0	11,204	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	6,527	198,862	0	0	0	0	0	0	0	0	205,389	26
27	Other (specify):*	(416,916)	0	0	0	0	0	0	0	0	0	0	(416,916)	27
28	**TOTAL General Administration**	(495,924)	(600,857)	210,530	0	0	0	0	0	0	0	0	(886,251)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(525,307)	(586,806)	210,530	0	0	0	0	0	0	0	0	(901,583)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number COUNTRYSIDE CARE CENTRE **#** 0040931 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(38,549)	7,629	198,756	0	0	0	0	0	0	0	0	167,836	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(26,417)	0	365,703	0	0	0	0	0	0	0	0	339,286	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	20,911	(762,850)	0	0	0	0	0	0	0	0	(741,939)	34
35	Rent-Equipment & Vehicles	0	9,645	0	0	0	0	0	0	0	0	0	9,645	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(64,966)	38,185	(198,391)	0	0	0	0	0	0	0	0	(225,172)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(590,273)	(548,621)	12,139	0	0	0	0	0	0	0	0	(1,126,755)	45

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF OWNERS		SEE ATTACHED LIST OF RELATED		FIRST HEALTH CARE ASSOCIATES, LTD.		MANAGEMENT/
		NURSING HOMES		(DIVISION OF FHC ENTERPRISE, INC.)		CONSULTANT
					MORTON GROVE, IL	
				COUNTRYSIDE HEALTHCARE CENTRE		
					MORTON GROVE, IL	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	NURSING	$	FHC ENTERPRISES INC.		$ 14,051	$ 14,051	1
2	V	17	ADMINISTRATIVE	806,893	MR. BELLOWS OWNS 1.5% OF THIS FACILITY		21,467	(785,426)	2
3	V	19	PROFESSIONAL FEES		AND 100% OF FHC ENTERPRISES		6,980	6,980	3
4	V	20	DUES & SUBSCRIPTIONS		" "		2,018	2,018	4
5	V	21	CLERICAL		" "		157,840	157,840	5
6	V	24	TRAVEL		" "		11,204	11,204	6
7	V	26	INSURANCE		" "		6,527	6,527	7
8	V	30	DEPRECIATION		" "		7,629	7,629	8
9	V	34	RENT		" "		20,911	20,911	9
10	V	35	RENT-EQUIPMENT & VEH.		" "		9,645	9,645	10
11	V								11
12	V								12
13	V								13
14	Total			$ 806,893			$ 258,272	$ * (548,621)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 762,850	COUNTRYSIDE HEALTHCARE CENTRE		$	$ (762,850)	15
16	V	19	ACCOUNTING FEES		" "		11,050	11,050	16
17	V	19	LEGAL FEES		" "		25	25	17
18	V	19	OTHER PROFESSIONAL		" "				18
19	V	21	BANK CHARGES		" "		593	593	19
20	V	26	GENERAL INSURANCE		" "		175,607	175,607	20
21	V	26	MORTGAGE INSURANCE		" "		23,255	23,255	21
22	V	30	DEPRECIATION - BLDG/IMP		" "		191,755	191,755	22
23	V	30	DEPRECIATION - EQPT/FURN		" "		7,001	7,001	23
24	V	32	AMORTIZATION - MTG COST		" "		2,972	2,972	24
25	V	32	INTEREST - MORTGAGE		" "		340,327	340,327	25
26	V	32	INTEREST - OTHER		" "		22,404	22,404	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 762,850			$ 774,989	$ * 12,139	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RELATED PARTY - FHC ENTERPRISES, INC.								$		1
2	SHAEL BELLOWS	MANGMT. CNSLT	ADMIN.	1.5%	SEE ATTACHED	3.6	14.88	SALARY	21,467	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 21,467		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: FHC ENTERPRISES INC.
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	496,459	9	$ 95,479	$ 95,479	73,062	$ 14,051	1
2	17	ADMINISTRATIVE	PATIENT DAYS	496,459	9	145,864	145,864	73,062	21,467	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	496,459	9	47,431		73,062	6,980	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	496,459	9	13,714		73,062	2,018	4
5	21	CLERICAL	PATIENT DAYS	496,459	9	190,601		73,062	28,051	5
6	21	CLERICAL	HOURS	1	1	129,789	129,789	1	129,789	6
7	24	TRAVEL	PATIENT DAYS	496,459	9	76,130		73,062	11,204	7
8	26	INSURANCE	PATIENT DAYS	496,459	9	44,347		73,062	6,527	8
9	30	DEPRECIATION	PATIENT DAYS	496,459	9	51,835		73,062	7,629	9
10	34	RENT	PATIENT DAYS	496,459	9	142,084		73,062	20,911	10
11	35	RENT - EQUIPMENT & VEH	PATIENT DAYS	496,459	9	65,539		73,062	9,645	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,002,813	$ 371,132		$ 258,272	25

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	RELATED PARTY - COUNTRYSIDE HEALTHCARE CENTRE						$	$			$	1
2	MIDLAND		X	MORTGAGE	VARIES	10/97	4,826,200	4,639,056	10/32	0.0745	340,327	2
3	MIDLAND		X	LOAN COST	35 YR AMORT	10/97	104,006	88,155			2,972	3
4												4
5												5
	Working Capital											
6	AMERICAN NATIONAL BNK		X	LINE OF CREDIT	VARIES	12/96	265,000	527,700	DEMAND	PRIME+	34,246	6
7	LOAN FROM PARTNERS	X		WORKING CAPITAL	VARIES	06/99	108,600	145,663	DEMAND	PRIME+	11,497	7
8	RELATED PARTIES	X		WORKING CAPITAL	VARIES	12/98	498,989	2,235,158	DEMAND	PRIME+	156,362	8
9	TOTAL Facility Related						$ 5,802,795	$ 7,635,732			$ 545,404	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,802,795	$ 7,635,732			$ 545,404	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	95,484	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	97,597	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,113	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	98,676	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ 304 For 1997 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$	(304)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	100,485	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	87,583	8
	1998	89,211	9
	1999	92,112	10
	2000	94,448	11
	2001	97,597	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME COUNTRYSIDE CARE CENTRE COUNTY KANE

FACILITY IDPH LICENSE NUMBER 0040931

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-19-176-009	NURSING HOME	$ 97,597.00	$ 97,597.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 97,597.00	$ 97,597.00

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,536 B. General Construction Type: Exterior BRICK Frame STEEL CNST Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	130,679	1981	$ 98,000	1
2	754 BASIS ADJ.		1982	16,345	2
3	TOTALS	130,679		$ 114,345	3

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	209		1981		$ 2,111,156	$	30	$ 70,059	$ 70,059	$ 1,500,091	4
5											5
6	754 BASIS AJ			1992	403,542	12,811	31.5	12,811		134,516	6
7											7
8											8
	Improvement Type**										
9	**********RELATED PARTY - COUNTRYSIDE HEALTHCARE										9
10	BUILDING IMPROVEMENTS			1982	40,076		15			40,076	10
11	VARIOUS IMPROVEMENTS			1983	26,282		15			26,282	11
12	VINYL TILING			1984	76,250	1,469	20	3,813	2,344	70,530	12
13	ROOF REPAIR			1985	6,644	349	20	332	(17)	5,810	13
14	VARIOUS IMPROVEMENTS			1986	1,609	85	15	107	22	1,763	14
15	VARIOUS IMPROVEMENTS			1987	36,433	1,157	20	1,822	665	28,241	15
16	BLACK TOP PAVING			1988	1,594	106	15	106		1,537	16
17	HOT WATER PIPING			1988	5,837	185	31.5	185		2,629	17
18	ROOFING IMPROVEMENTS			1989	51,879	1,647	31.5	1,647		22,578	18
19	SHOWER STALLS			1990	7,000	222	31.5	222		2,775	19
20	PAVING			1990	7,930	529	15	529		6,612	20
21	VARIOUS IMPROVEMENTS			1991	24,486	777	20	1,224	447	14,084	21
22	VARIOUS IMPROVEMENTS			1992	43,773	1,390	31.5	1,390		14,459	22
23	VARIOUS IMPROVEMENTS			1993	13,286	421	31.5	421		4,149	23
24	VARIOUS IMPROVEMENTS			1993	40,598	1,041	39	1,041		9,671	24
25	VARIOUS IMPROVEMENTS			1994	221,766	5,494	39	5,494		44,916	25
26	VARIOUS IMPROVEMENTS			1994	55,030	4,167	15	4,167		35,416	26
27	KITCHEN REMODEL/SIGNS			1995	32,836	842	39	842		6,668	27
28	ELECTRICAL & LIGHTING			1995	31,634	811	39	811		5,166	28
29	ROOFING/DOORS/DUCTWORK			1995	15,211	390	39	390		2,500	29
30	ROOF REPAIRS/FIRE DAMPERS			1996	4,300	110	39	110		757	30
31	BLACK TOP PAVING			1996	3,400	87	39	87		533	31
32	DUCTWORK			1996	8,584	220	39	220		1,329	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	REMOVE & REPLACE HVAC ROOF UNITS	1998	$ 28,363	$ 727		$ 727	$	$ 3,120	37
38	ROOF REPAIRS - PATCHING	1998	6,500	167		167		814	38
39	STAINLESS DUCTWORK - KITCHEN EXHAUST	1998	3,987	102		102		506	39
40	BOILER	1998	6,556	168		168		777	40
41	WALLCOVERING, CARPETING, ARCHITECT WORK	1999	58,243	2,118		2,118		8,384	41
42	WALLCOVERING, ALARMS/ELECTRIC WORKS	1999	27,515	1,000		1,000		3,876	42
43	REMODEL KITCHEN/WALLCOVERINGS/DRYWALL	1999	11,104	404		404		1,532	43
44	DINING RMS/WASHROOM - REMODEL/NEW ROOF	1999	165,984	6,035		6,035		22,381	44
45	LANDSCAPING/SECURITY PROJECT	1999	38,968	1,417		1,417		5,137	45
46	CONCRETE PATIO/DRAINAGE/DUCTWORK	1999	26,186	952		952		3,372	46
47	FLOOR TILES/WALLCOVERING/WALL REPAIRS	1999	127,185	4,624		4,624		15,992	47
48	IRRIGATION SYSTEM/BTY STATIONS	1999	26,058	947		947		3,196	48
49	NEW ADDITION/EXHAUST FANS/INTERIOR WORK	1999	843,269	30,661		30,661		98,375	49
50	REMODEL-OFFICES/BATHROOMS/DINING	2000	72,465	2,635		2,635		7,795	50
51	FIRE DAMPERS AND FLOOR GRILLES	2000	5,226	190		190		562	51
52	DOORS/LAUNDRY RM/CORRIDOR - REMODEL	2000	64,257	2,336		2,336		6,133	52
53	ELEVATOR OPERATIONG PANEL	2000	4,490	163		163		428	53
54	LINT COLLECTOR/REMODELING PLANS	2000	7,595	276		276		679	54
55	SPRINKLER SYSTEMS	2000	8,550	311		311		765	55
56	ELEVATOR WANDERGUARD SYSTEM	2000	5,282	192		192		456	56
57	KITCHEN REMODELING/CARPETING	2000	82,957	3,016		3,016		7,164	57
58	HOT WATER REC. - MIXING VALVE & CIRCUIT SETTERS	2000	8,604	313		313		717	58
59	FRESH AIR INTAKES/ROOF STANDS	2000	23,244	845		845		1,937	59
60	FIRE ALARM/DOORS	2000	6,184	225		225		516	60
61	PARKING LOT EXPANSION	2000	35,624	1,295		1,295		2,968	61
62	GENERATORS	2000	92,626	3,368		3,368		7,438	62
63	LANDSCAPING/SECURITY PROJECT	2000	12,625	842		842		2,104	63
64	RESIDENT ROOM REMODELING & FURNISHING	2000	67,311	2,447		2,447		5,404	64
65	PATIENT WANDERING SYSTEM	2000	14,541	529		529		1,168	65
66	SIR FREE LINT FILTER	2000	1,399	51		51		113	66
67	NEW ROOF	2000	20,995	763		763		1,622	67
68	RESIDENT ROOM REMODELING & FURNISHING	2000	103,610	3,767		3,767		8,005	68
69	ROOF REPAIRS	2000	3,300	120		120		255	69
70	TOTAL (lines 4 thru 69)		$ 5,281,939	$ 107,316		$ 180,836	$ 73,520	$ 2,206,779	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,281,939	$ 107,316		$ 180,836	$ 73,520	$ 2,206,779	1
2									2
3	ROOF REPAIR & METACAULK FIRE STOP	2000	11,211	408		408		833	3
4	ROOF TOP HVAC UNIT	2000	7,350	267		267		545	4
5	ELECTRICAL WORK/RESIDENT RMS REMODEL	2000	109,053	3,965		3,965		8,096	5
6	REMOVE/INSTL FLOORING & DRYWALL-KITCHEN, LNDR	2001	16,675	606		606		1,137	6
7	METAL SUPPORTS ON AIR RETURNS TO ROOF	2001	3,300	120		120		225	7
8	INSTALL HYDRAULIC PUMPING UNIT-KITCHEN ELEVATO	2001	7,495	273		273		489	8
9	REPLACE WATER CLOSETS & FLUSH VALVES-KITCHEN	2001	7,737	281		281		457	9
10	NEW HALL DOOR LOCKING ASSEMBLIES-ALL FLOORS	2001	2,885	105		105		162	10
11	PUMP FOR IRRIGATION SYSTEM	2001	1,825	66		66		102	11
12	INSTALL 4" FLOOR CLEANOUT ON SANITARY WASTE LIN	2001	6,783	247		247		257	12
13	INSTALLED 4 ELECTRIC HEATERS - CUSTOM	2002	5,297	185		185		185	13
14	ELECTRICAL WIRING FOR DISHWASHER & BOOSTER HTI	2002	14,988	522		522		522	14
15	SHWR RM REPAIRS, REMOVED OLD & FURNISH/INST. NEV	2002	26,388	920		920		920	15
16		2002	2,289	24		24		24	16
17	REMOVED & INSTALLED 2 HEAT EXCHANGERS	2002	2,040	15		15		15	17
18	REMOVE & INSTALL ROOFTOP HEAT EXCHANGER	2002	1,523	2		2		2	18
19	PARKING LOT - REMOVE AND REPLACE ASPHALT	2002	87,477	2,913		2,913		2,913	19
20									20
21									21
22			ADJ TO SL	73,520			(73,520)		22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,596,255	$ 191,755		$ 191,755	$	$ 2,223,663	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 739,884	$ 94,804	$ 61,781	$ (33,023)	3-15 YRS	$ 247,732	71
72	Current Year Purchases	36,838	7,368	1,842	(5,526)	3-15 YRS	1,842	72
73	Fully Depreciated Assets	9,150					9,150	73
74	RELATED PARTY	698,431	14,630	14,630			640,992	74
75	TOTALS	$ 1,484,303	$ 116,802	$ 78,253	$ (38,549)		$ 899,716	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,194,903	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 308,557	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 270,008	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (38,549)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,123,379	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 18,037 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY USE	99 DODGE RAM PR 2W	$ 295.13	$ 3,246	17
18					18
19					19
20					20
21	TOTAL		$ 295.13	$ 3,246	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 137,545	$		$ 137,545	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			36,253			36,253	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			182,286			182,286	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				106,744		106,744	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	LAB, X-RAY, RENTALS, I.V. TPY & Other (specify): MEDICAL SUPPLIES	39-2					109,409		109,409	13
14	TOTAL			$		$ 356,084	$ 216,153		$ 572,237	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 698,846	$ 779,953	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 76,284)	1,972,411	1,972,411	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	48,476	142,491	6
7	Other Prepaid Expenses	2,524	31,319	7
8	Accounts Receivable (owners or related parties)	74,130	170,739	8
9	Other(specify): EMPLOYEE LOANS	384	384	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,796,771	$ 3,097,297	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		98,000	13
14	Buildings, at Historical Cost		2,111,156	14
15	Leasehold Improvements, at Historical Cost		3,081,555	15
16	Equipment, at Historical Cost	785,871	785,871	16
17	Accumulated Depreciation (book methods)	(544,912)	(2,951,458)	17
18	Deferred Charges	1,230	89,385	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		514,077	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 242,189	$ 3,728,586	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,038,960	$ 6,825,883	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 398,771	$ 421,667	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	209,645	209,645	28
29	Short-Term Notes Payable	527,700	732,857	29
30	Accrued Salaries Payable	123,314	123,314	30
31	Accrued Taxes Payable (excluding real estate taxes)	17,849	17,849	31
32	Accrued Real Estate Taxes(Sch.IX-B)		98,676	32
33	Accrued Interest Payable	125	125	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	MANAGEMENT FEES	753,603	753,603	36
37	NOTES PAYABLE - RELATED	2,270,069	2,270,069	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,301,076	$ 4,627,805	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	47,184	47,184	39
40	Mortgage Payable		4,639,056	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 47,184	$ 4,686,240	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,348,260	$ 9,314,045	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,309,300)	$ (2,488,162)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,038,960	$ 6,825,883	48

***(See instructions.)**

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,127,063)	1
2	Restatements (describe):		2
3			3
4	ROUNDING ADJ.	8	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,127,055)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(182,245)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (182,245)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,309,300)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,133,482	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,133,482	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	142	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,140	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,282	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	26,417	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 26,417	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,161,181	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,305,343	31
32	Health Care	4,175,266	32
33	General Administration	3,010,524	33
	B. Capital Expense		
34	Ownership	1,166,492	34
	C. Ancillary Expense		
35	Special Cost Centers	572,237	35
36	Provider Participation Fee	113,564	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,343,426	40
41	**Income before Income Taxes (line 30 minus line 40)****	(182,245)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (182,245)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,909	2,086	$ 72,477	$ 34.74	1
2	Assistant Director of Nursing	1,941	2,103	61,716	29.35	2
3	Registered Nurses	26,435	30,807	791,338	25.69	3
4	Licensed Practical Nurses	22,624	23,907	591,860	24.76	4
5	Nurse Aides & Orderlies	125,468	132,098	1,838,936	13.92	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,151	5,711	89,444	15.66	8
9	Activity Director	2,468	2,613	33,950	12.99	9
10	Activity Assistants	10,302	11,789	104,059	8.83	10
11	Social Service Workers	3,044	3,618	54,451	15.05	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	11,166	12,136	157,662	12.99	14
15	Cook Helpers/Assistants	17,523	18,029	136,923	7.59	15
16	Dishwashers					16
17	Maintenance Workers	2,007	2,232	45,110	20.21	17
18	Housekeepers	23,477	24,836	216,346	8.71	18
19	Laundry	6,842	7,594	67,315	8.86	19
20	Administrator	1,933	2,086	98,445	47.19	20
21	Assistant Administrator	3,745	4,292	108,372	25.25	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,324	10,580	159,108	15.04	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	7,454	8,056	167,688	20.82	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	282,813	304,573	$ 4,795,200 *	$ 15.74	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	207	$ 10,160	1-3	35
36	Medical Director	72	12,000	9-3	36
37	Medical Records Consultant	48	2,112	10-3	37
38	Nurse Consultant	418	16,533	10-3	38
39	Pharmacist Consultant	96	2,200	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	38	2,090	11-3	44
45	Social Service Consultant	82	3,535	12-3	45
46	Other(specify) PSYCHO SOCIAL	34	1,843	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	995	$ 50,473		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,990	$ 99,944	10-3	50
51	Licensed Practical Nurses	1,631	60,209	10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)	3,621	$ 160,153		53

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
KIM KOHLS	ADMIN		$ 98,445
VIVIAN MC CAIN	ASST ADMIN		49,240
JEAN JOHNSON	ASST ADMIN		59,132
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 206,817

B. Administrative - Other

Description	Amount
FIRST HEALTH CARE - MANAGEMENT FEES	$ 806,893
TOTAL (agree to Schedule V, line 17, col. 3)	$ 806,893
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		214,274
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 214,274

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 86,748
Unemployment Compensation Insurance	46,435
FICA Taxes	364,452
Employee Health Insurance	270,079
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	17,372
EMPLOYEE PHYSICAL EXAMS	607
PENSION/PROFIT SHARING PLANS	178
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 785,871

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	19,866
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	56,513
TRUST/FRANCHISE/CONTRIB/ETC	5,720
LICENSES & PERMITS	270
DUES & SUBSCRIPTIONS	8,256
MGMT CO ALLOCATION	2,018
TRUST/FRANCHISE/CONTRIB/ETC	(5,720)
Less: Public Relations Expense	(0)
Non-allowable advertising	(42,206)
Yellow page advertising	(14,307)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 30,410

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	1,591
RELATED PARTY	11,204
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,795

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINT/DECORATING	1999	$ 9,371	3	$ 1,562	$ 3,124	$ 3,124	$ 151	$	$	$	$	$
2	PAINT/DECORATING	2001	2,369	3			395	790	790	394			
3	PAINT/DECORATING	2002	2,374	3				396	791	791	396		
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 14,114		$ 1,562	$ 3,124	$ 3,519	$ 1,337	$ 1,581	$ 1,185	$ 396	$	$

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL. COUNCIL ON LTC - $7691.2**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **7,828** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **113,564**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? _____ Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: COUNTRYSIDE CARE CENTRE **#0040931** **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	10,160	
	REPAIRS & MAINTENANCE		2,727	
			0	12,887
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		8,995	
			0	8,995
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		46,979	
	ELECTRICITY		79,638	
	WATER		63,389	
	CABLE TV - LOBBY		0	
			0	190,006
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		13,641	
	PAINTING & DECORATING		2,374	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		28,552	
	ELEVATOR MAINTENANCE & REPAIR		3,757	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		6,500	
	FIRE SERVICE		1,781	
	DEFFERED MAINTENANCE		820	
			0	
			0	57,425
7	**OTHER**			
	SCAVENGER		32,260	
	SECURITY SERVICE		1,523	33,783
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	12,000	12,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	160,153	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	2,112	
	PHARMACY CONSULTANT	XVIII B 39-2	2,200	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	16,533	
	PSYCHO SOCIAL	XVIII B 46-2	1,843	
			0	182,841
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		7,870	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		7,063	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	14,933
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		10,754	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,090	
			0	12,844
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	3,535	
			0	3,535
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number COUNTRYSIDE CARE CENTRE **#0040931** **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	806,893	806,893
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	17,503	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	196,771	
			0	214,274
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	42,206	
	EMPLOYEE WANT ADS	XIX F	19,866	
	CONTRIBUTIONS	VI 20 XIX F	1,470	
	DUES & SUBSCRIPTIONS	XIX F	8,256	
	LICENSES & PERMITS	XIX F	270	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	14,307	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	4,250	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	90,625
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		2,596	
	EQUIPMENT REPAIR & MAINTENANCE		13,428	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	211	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		1,636	
	TELEPHONE		37,215	
	MESSENGER SERVICE		1,845	
			0	56,931

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	364,452	
	UNEMPLOYMENT COMPENSATION	XIX D	46,435	
	WORKERS COMPENSATION INSURANC	XIX D	86,748	
	HOSPITALIZATION INSURANCE	XIX D	270,079	
	EMPLOYEE BENEFITS - OTHER	XIX D	17,372	
	EMPLOYEE PHYSICAL EXAMS	XIX D	607	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	178	
	CHICAGO HEAD TAX	XIX D	0	785,871
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		31,365	31,365
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	1,591	
			0	
			0	1,591
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		6,206	6,206
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		190,611	190,611
27	**OTHER**			
	BAD DEBTS	VI 24	416,916	
			0	416,916

GRAND TOTAL COLUMN 3 OTHER 3,130,532

COUNTRYSIDE CARE CENTRE
EMPLOYEE MEAL RECLASSIFICATION
12/31/2002

TOTAL FOOD PURCHASE	252,163
LESS SALES TAX	(1,881)
NET FOOD	250,282
TOTAL PATIENT CENSUS	73,062
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	219186
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	219186
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	219186
NET FOOD	250282
DIVIDE TOTAL MEALS/YEAR	219186
COST PER MEAL	1.14
TIME EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	0

COUNTRYSIDE CARE CENTRE
RECONCILIATION OF COST REPORT TO FINANCIAL STATEMENTS
12/31/2002

INCOME PER F/S										10,086,166	
		NURSING	EMPL BENEFITS	PLANT	LAUNDRY	DIETARY	GENL/ADMIN	OTHER INC/EXP	CAPITAL		SALARIES
PER COST REPORT		4,175,266	785,871	615,484	102,279	587,580	2,224,653	113,564	1,166,492		4,795,200
ADJUSTMENTS:											
	EQUIPMENT RENTAL/AUTO LEASE	7,864		434			12,985		(21,283)		
	CABLE TV			0			0				
	CONTRACT NURSING										160,153
	INTEREST INCOME							(26,417)			
	NET VENDING COMMISSIONS										
	EMPLOYEE PHYSICAL EXAMS		(607)				607				
	INSURANCE - EXECUTIVE LIFE		0				0				
	MANAGEMENT FEES						(806,893)		806,893		
	O2 INCOME/RENT INSURANCE						(175,607)		175,607		
	BAD DEBTS						(416,916)	416,916			
	DISCOUNTS LOST							0			
	ANCILLARIES	572,237							0		
	SETTLEMENT INTEREST/OTHER INCOME							(1,140)			
	RECLASSED SALARIES	(43,078)	0	0	0	0	43,078	0	0		
	PROFIT SHARING	0	0	0	0	0	0	0	0		
	PRIOR EXPENSES	0	0	0	0	0	0	(47,316)	0		
	BENEFITS REBILLED	0	0	0	0	0	0	0	0		
	RENT/INTEREST	0	0	0	0	0	0	0	0		
	NURSE AID REIMB-STATE	0	0	0	0	0	0	(142)	0		
TOTAL COSTS		4,712,289	785,264	615,918	102,279	587,580	881,907	455,465	2,127,709	10,268,411	4,955,353
PER FINANCIAL STATEMENTS		4,712,289	785,264	615,918	102,279	587,580	881,907	455,465	2,127,709	(182,245)	4,955,353
NET INCOME (LOSS) BEFORE INCOME TAXES PER FINANCIAL STATEMENTS										(182,245)	

COUNTRYSIDE CARE CENTRE - COMPARISONS - 12/31/2002

	ref.	12/31/2002			12/31/2001			DIFF	12/31/2000		
CAPACITY DAYS		75,709			76285			(576)	76494		
CENSUS DAYS		73,062			67223			5,839	65953		
OCCUPANCY %		96.50%			88.12%				86.22%		
SALARIES											
TOTAL General Services	8-1	623,356	6.76%	8.53	641677	7.54%	9.55	(18,321)	631923	8.30%	9.58
Social Services	12-1	54,451	0.59%	0.75	56713	0.67%	0.84	(2,262)	54079	0.71%	0.82
TOTAL Health Care and Programs	16-1	3,805,919	41.29%	52.09	3267126	38.39%	48.60	538,793	2853912	37.51%	43.27
Clerical & General Office Expenses	21-1	159,108	1.73%	2.18	155030	1.82%	2.31	4,078	142168	1.87%	2.16
TOTAL General Administration	28-1	365,925	3.97%	5.01	364052	4.28%	5.42	1,873	282285	3.71%	4.28
TOTAL Operation Expense	29-1	4,795,200	52.03%	65.63	4272855	50.20%	63.56	522,345	3768120	49.52%	57.13
ADJUSTED TOTALS											
Food	2-8	250,282	2.72%	3.43	268753	3.16%	4.00	(18,471)	238660	3.14%	3.62
Heat and Other Utilities	5-8	190,006	2.06%	2.60	199925	2.35%	2.97	(9,919)	170133	2.24%	2.58
Maintenance	6-8	139,211	1.51%	1.91	153827	1.81%	2.29	(14,616)	152148	2.00%	2.31
TOTAL General Services	8-8	1,294,220	14.04%	17.71	1363251	16.02%	20.28	(69,031)	1316464	17.30%	19.96
Administrative	17-8	220,895	2.40%	3.02	223240	2.62%	3.32	(2,345)	136734	1.80%	2.07
Directors Fees	18-8	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
Professional Services	19-8	230,521	2.50%	3.16	219251	2.58%	3.26	11,270	317846	4.18%	4.82
Fees, Subscriptions, Promotions	20-8	30,410	0.33%	0.42	40653	0.48%	0.60	(10,243)	43563	0.57%	0.66
License Fee-IDPA	Pg21	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
License Fee-Other	Pg21	270	0.00%	0.00	5360	0.06%	0.08	(5,090)	369	0.00%	0.01
Clerical & General Office Expenses	21-8	410,210	4.45%	5.61	401474	4.72%	5.97	8,736	404455	5.32%	6.13
Employee Benefits & Payroll Taxes	22-8	785,871	8.53%	10.76	647614	7.61%	9.63	138,257	519209	6.82%	7.87
Payroll Taxes	Pg21	410,887	4.46%	5.62	358906	4.22%	5.34	51,981	319087	4.19%	4.84
W/C Insurance	Pg21	86,748	0.94%	1.19	64882	0.76%	0.97	21,866	55799	0.73%	0.85
Health Insurance	Pg21	270,079	2.93%	3.70	201957	2.37%	3.00	68,122	115217	1.51%	1.75
Inservice Training & Education	23-8	31,365	0.34%	0.43	13604	0.16%	0.20	17,761	14607	0.19%	0.22
Travel and Seminar	24-8	12,795	0.14%	0.18	13116	0.15%	0.20	(321)	13420	0.18%	0.20
Other Admin. Staff Transportation	25-8	6,206	0.07%	0.08	4749	0.06%	0.07	1,457	4341	0.06%	0.07
Insurance-Prop.Liab.Malpractice	26-8	396,000	4.30%	5.42	177258	2.08%	2.64	218,742	134316	1.77%	2.04
Other (specify):*	27-8	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
TOTAL General Administration	28-8	2,124,273	23.05%	29.07	1740959	20.45%	25.90	383,314	1588491	20.88%	24.09
TOTAL Operation Expense	29-8	7,589,550	82.35%	103.88	6905955	81.14%	102.73	683,595	6215367	81.68%	94.24
Real Estate Taxes	33-3	100,485	1.09%	1.38	96812	1.14%	1.44	3,673	95040	1.25%	1.44
Real Estate Legal	Pg10	0	0.00%	0.00				0	0	0.00%	0.00
GRAND TOTAL COST	45-8	9,216,671	100.00%	**126.15**	8511197	100.00%	**126.61**	705,474	7609227	100.00%	**115.37**
8-8 + (28-8 - 22-8) + 28-8*(8-1 + 28-1)/29-1		2794752.3	30.32%	**38.25**	2609029	30.65%	**38.81**	185,723	2511714.7	33.01%	**38.08**

COUNTRYSIDE CARE CENTRE - DIAGNOSTICS - 12/31/2002

This report DOES NOT REFLECT a 365-day year.
Page 3 Column 3 - Other is completely scheduled.
Total Salaries on Page 3 Line 29-1 = Page 20 Line 34-3.
Total Adj on Page 4 Line 45-7 = Page 5 Line 37.
Deferred maint. adj. on Page 5A Line 1 consists of 1337 from Page 22 and -2374 from Page 3 Line 6-3.
Ancillaries on Page 4 Line 39-6 = Page 16 Line 14-8.
Interest Expense on Page 4 Line 32-4 DOES NOT EQUAL Page 9 Line 15-10. Diff=-365702
Real estate tax expense on Page 4 Line 33-4 = Page 10 Line 7.
Real estate tax accrual on Page 10 Line 4 DOES NOT EQUAL Page 17 Line 32-1.
Depn expense on Page 4 Line 30-4 DOES NOT EQUAL Page 13 Line 82-2. Diff=-206385
Depreciation expense on Page 4 Line 30-8 = Page 13 Line 83-2.
Facility rent on Page 4 Line 34-4 DOES NOT EQUAL Page 14 Line 7-4.
Equipment rent on Page 4 Line 35-4 = Page 14 Line 16 + Line 21-4.
Nurse aide training on Page 3 Line 13-8 = Page 15 Line 9-4.
Total equity on Page 17 Line 47-1 = Page 18 Line 24-1.
Page 17 Assets = Liabilities & Capital.
Net income on Page 18 Line 7-1 = Page 19 Line 43-2.
Administrative Salaries on Page 3 Line 17-1 = Page 21-A.
Management fees on Page 3 Line 17-3 = Page 21-B.
Professional fees on Page 3 Line 19-3 = Page 21-C.
Employee benefits/Payroll taxes on Page 3 Line 22-8 = Page 21-D.
Dues, etc. on Page 3 Line 20-8 = Page 21-F.
Travel expenses on Page 3 Line 24-8 = Page 21-G.